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Restructuring Through Budget Cuts is...

No Substitute For Reform

The Massachusetts Fiscal Crisis and Change in Privately Provided Community-Based Human Services

The Impact of the Massachusetts Fiscal Crisis on Human Services
Update Report for Fiscal Year 1991

May 1991

Social Policy Research Group, Inc.
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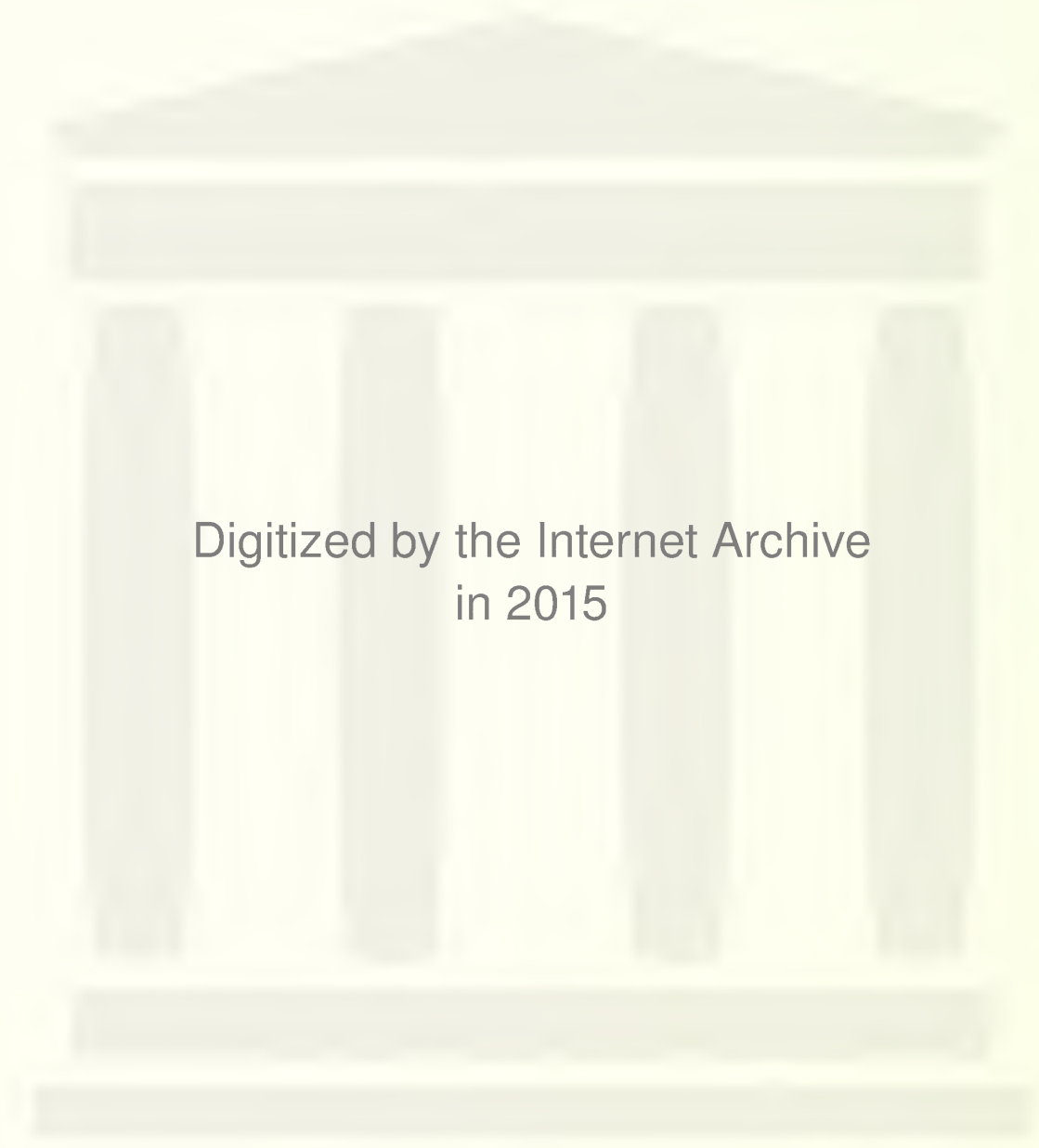
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TO THE READER...

Balancing the budget has become the primary goal of Massachusetts government -- of this there can be little doubt. Both the Governor and Legislature are under enormous pressure, from voters and from Wall Street, to bring the state budget into balance and end the Commonwealth's seemingly interminable fiscal crisis, now in it's fourth year. The looming budget problem has constrained or eclipsed other policy choices. It has forced government to propose cuts and changes which would not even be considered in ordinary times. And, so far, the effort to achieve balance has fallen short. Spending growth in a few program areas (labeled budget busters), very poor revenue growth, and a severe economic recession have combined to prolong and deepen the crisis. With or without new taxes, it is clear that balancing the budget requires painful cuts in programs and services.

The purpose of this report is to continue to document the impact that these cuts are already having on privately provided community-based human services. It concludes that the system of care is about to undergo a massive restructuring driven, not by policy deliberations, but by budgetary forces. The recommendations we offer are designed to help state decision-makers consider how the budget pressures dominating today's debate may constrain long-term reform objectives.

James B. Hyman, Ph.D.
President

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The Massachusetts Fiscal Crisis and Change in Privately Provided Community-Based Human Services

The Impact of the Massachusetts Fiscal Crisis on Human Services
Update Report for Fiscal Year 1991

Social Policy Research Group, Inc.

Principal Investigator: Stephen D. Minicucci
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President: James B. Hyman, Ph.D.
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May 1991

Overview of the Budget Crisis Impact Study

This report is one of a series being produced by the Social Policy Research Group as part of a multi-year project to study "The Impact of the Massachusetts Fiscal Crisis on Human Services." The study, now in its second year, was launched in response to growing concerns in the community that the on-going crisis would severely affect the quality and quantity of human services available to the Commonwealth's residents. In September, 1990, at the conclusion of the study's first year, SPRG released two reports: *Stressing the System: The Impact of the Massachusetts Fiscal Crisis on Human Services in Boston*, which summarized the study and its findings up to that time; and a *Primer on Human Services in Boston*, which provided a first-ever profile of the private-provider community at work in the city. These initial reports mirrored the two stated goals of the study: first, to understand human service delivery; and second, to document the effects of the budget crisis. Most of the findings presented in this report are based on the 1991 Budget Crisis Impact Survey, an extensive mail and telephone survey conducted earlier this year.

The project employs a very broad definition of human services but focuses on privately provided, community-based services and their place in the larger human services system. This focus was chosen because private providers, funded through state purchase-of-service contracts, are the primary mechanism of human service delivery for most citizens, yet are so poorly understood that a senior state policy maker -- after two years of studying the system -- called them a "black hole". The study uses comprehensive telephone, mail, and in-person surveys of providers as principal data collection tools, augmented with analyses of budgetary data and discussions with advocates and government officials. Most of the findings in this report are based on the 1991 Budget Crisis Impact Survey, an extensive mail and telephone survey conducted earlier this year.

This special report provides a preliminary presentation and discussion of the second year of project work. It will be followed in the autumn by a full report that explores these results in greater depth. We have made a special effort to release this preliminary report in advance of the full analysis because of the urgency of the issues we raise here, and in hopes that the information and insights offered will assist policy-makers and the general public during these difficult times. SPRG is also currently planning a comprehensive survey of human service clients which will complement the provider-based research presented here and provide the basis for planning large-scale reforms.

Finally, unlike the September 1990 reports, which dealt almost exclusively with Boston-based human services, this report includes data collected from providers from across the state. This more extensive effort was undertaken in direct response to widespread requests from communities outside Boston for a broader project focus.

Acknowledgments

The board and staff of the Social Policy Research Group would like to thank the provider community for its continuing cooperation in this endeavor. We would also like to acknowledge the contributions of the members of the project's steering and technical advisory committees as well as the many others who have provided information, assistance, and counsel to this effort. In particular, we would like to acknowledge the contributions of those institutions which assisted in the 1991 budget crisis survey: The United Ways of Massachusetts, the United Way of Pioneer Valley and the Springfield Community Council, the United Way of Central Massachusetts, the Old Colony United Way, the United Way of Greater New Bedford, the United Way of Merrimack Valley, and the Division of Purchased Services in the Executive Office for Administration and Finance (Commonwealth of Massachusetts).

The project has enjoyed the support of several funders whom we gratefully acknowledge below.

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The Social Policy Research Group

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PART I:

SUMMARY

SUMMARY: THE CONFLICT BETWEEN BUDGET AND REFORM POLICIES

State support for most human service programs declined in fiscal year 1991. There were exceptions, of course: Medicaid spending rose, along with the cost of public assistance programs -- the latter a predictable result of economic hard times. Beyond these two areas, budget increases occurred only for corrections and for required child and family services. Funding for virtually all other human services, whether provided in public institutions or privately in community settings, declined.

What are the implications of this receding tide for community-based human services? How have private agencies and private funders responded to it? How have the people served by these agencies been affected? How has the system of care itself changed? And, finally, what are the implications for budget choices and other policy decisions? These are the kinds of questions that the Social Policy Research Group (SPRG) first asked in the beginning of fiscal year 1990, when this study began, and repeated in publications last fall. The questions are still valid today -- but they are more urgent. Only widespread cuts, new taxes, and large one-time financial manoeuvres will prevent the 1991 state deficit from exceeding last year's of some $1.3 billion. And fiscal year 1992 promises to be the worst yet. Governor Weld quickly followed his already spare 1992 budget plan -- including $1.5 billion in "downsizing and cost reduction measures"[1] -- with proposals for nearly $1 billion in additional cuts. The House of Representatives has since followed with an even leaner budget. At this writing, tax revenues for fiscal year 1992 are expected to fall by 6.2%!

As the stakes in the budget struggle rise, pressures are mounting to restructure and redefine the business of state government. Last September, in this project's first report, we wrote that the crisis was leading "finally to absolute choices among state-supported programs and a permanent alteration to the menu of services available."[2] Now, only eight months later, administration officials and legislative leaders have arrived at this very precipice: they are discussing the elimination or major restructuring of many programs, mainly in the public assistance arena. Although many of these proposals may prove to be trial balloons, the course does seem clear.

As the duration and depth of the crisis increase, the stresses mounting against the system of privately provided, community-based human services are becoming inescapable as well. Major change in the system -- marked, in particular, by increased consolidation -- now appears imminent. This restructuring will not be the direct result of policy deliberations and debate, instead it will be driven mainly by budget cuts. In the collision between budget-balancing and reform policies, the budget clearly takes precedence, at least for now. But the dominant budget issue does not just eclipse reform, it can conflict with it and generate unintended results. For example, the trend toward increased consolidation suggested by this research is

not compatible with the precepts of "entrepreneurial government" designed to take advantage of competition among providers. Since the Weld administration draws guidelines for reform from the entrepreneurial model, consolidation will make some of the Governor's implied reform objectives more difficult to achieve. We urge that the state carefully monitor for unintended consequences of budget cuts and act to preserve options for reform. Major restructuring ought to reflect deliberate policy choices. Budget cuts are no substitute for reform. If the entrepreneurial paradigm urges the state to *steer* rather than *row*, restructuring without reform represents *drift*.

The summary section which follows presents the key findings and conclusions we have drawn from our 1991 Budget Crisis Impact Survey and earlier research. It offers some preliminary recommendations for policymakers. Following the summary is a more detailed presentation of the survey findings. Appendices to the report discuss regional differences in the data and the 1991 Budget Crisis Impact Survey itself.

Summary Findings and Conclusions

From the wealth of detailed findings emerging from the survey, three general findings are especially notable:

The fiscal crisis is deepening and its impacts on community-based care are intensifying. The most important general finding to which our survey data point is that a variety of measures -- revenues, finances, staffing, and program offerings -- all indicate a system of private service provision which is now being stressed to its limit.

The system of care is doing more with less but is still serving an increasingly smaller portion of those in need. The survey results also describe a system that has managed to serve more clients despite funding reductions, but which still continues to fall behind in meeting the needs of the community. As a result, waiting lists continue to grow. This trend is compounded by a marked increases both in the needs of individual clients and the community.

Charitable sources of funding for human services are inadequate to replace declining governmental support. Not only is funding from private charitable sources (including personal contributions, United Way allocations, and grants from private foundations and trusts) a small part of overall agency resources -- equaling only 8% of total agency revenues in fiscal year 1991 -- total revenues from these sources actually **fell** by 0.6% over the year, mainly due to declines in United Way resources. Although private funders can play an important role in the human services system, they cannot supplant the state and provide major, on-going support for programs and services across the breadth of the system.

These findings, as well as our deepening understanding of the system of care in Massachusetts, lead us to two key conclusions.

Major structural change in the private system of community-based care is imminent, and will be driven mainly by budgetary pressures, not policy considerations aimed at reform.

— Increasing consolidation of the system of care will be a major element of this restructuring. It will principally result from declining revenues and poor and deteriorating finances that have made the network of private human service providers increasingly unstable and vulnerable to state budget cuts. No state-wide policy, except for the drive to balance the budget, appears to lie behind this trend.

— The movement toward services reimbursable through Medicaid is another key trend in private human services. As with consolidation, this trend is being driven by efforts to balance budgets, rather than any programmatic concerns. The move to maximize federal revenues by increasing Medicaid spending conflicts directly with the larger drive to control Medicaid spending, even though both are aimed at deficit reduction. This situation creates special challenges for state managers.

— Because restructuring is dominated by budgetary considerations, the system that survives the crisis is unlikely to reflect any particular policy preferences. Also, because the changes underway now will likely become concretized, any obstacles to reform created in this process will likely persist for the foreseeable future.

Budget requirements take precedence over, and often conflict with, reform policy goals. In particular, we cite three examples:

— Increasing consolidation in the system of care is inconsistent with the entrepreneurial policy goals of increased vendor competition and client choice. Since these principles appear to form an important part of the administration's nascent reform agenda, one effect of the fiscal crisis may be to make some of the implicit goals of the Weld administration harder to achieve.

— The need to maximize budget savings threatens to undercut the reform impulse embedded in the effort to deinstitutionalize the patients of state schools for the mentally retarded and state-run mental and public health hospitals. Funding for community-based care proposed in the Governor's budget request does not appear adequate to successfully support this reform.

— The shift toward services reimbursible through Medicaid is likely to have far-reaching effects on the menu of services available to the state's residents. As with consolidation, some of these impacts may conflict with elements of the entrepreneurial model.

The remainder of this section documents the deepening crisis among private provider agencies, discusses the directions in which the system of care is evolving, and contrasts these to policy statements made by the Weld administration. It concludes with initial recommendations concerning the budget and reform policies related to private human service delivery.

A Deepening Crisis Among Private Providers

The portrait of privately provided human services in fiscal year 1991 which emerges from SPRG's research is one of limited resources and weak and deteriorating finances. It is a portrait of program closings and staff cutbacks. It is also one of rising need and demand for services, with rising caseloads (despite reduced funding), longer waits for services, and increasing client and community needs. Finally, on nearly every measure, the level of stress being experienced by the system of care is greater than what we documented for fiscal year 1990 in *Stressing the System.*

Resource Scarcity. Reports of declining agency revenues were widespread in fiscal year 1991, with agency budgets shrinking in fully 40% of all cases. Of revenue sources itemized in the survey, only Medicaid, Medicare, and fees paid by clients rose at rates which surpassed inflation. State contract awards, other governmental funding, and United Way allocations all declined. After adjusting for inflation, 70% of all agencies had less resources, and four out of five had fewer state contract dollars.

Finances Weak. The financial positions of provider agencies are poor and declining. The majority of agencies do not enjoy access to endowments or other reserves. And, when these are present, they tend to be small compared to agency budgets. Fully 70% of all agencies reported less than one month's worth of reserves or no reserves at all. Because of this, even very small shocks -- such as payment delays -- could be devastating to the majority of providers. Combined, agencies reported a small operating surplus for fiscal year 1990 but an overall deficit in 1991. For one out of every five agencies, fiscal year 1991 was at least the second deficit year. Thirty-nine percent of responding agencies reported that endowments and other reserves were being consumed to fill budget gaps.

Staffing Pressures. Forty-six percent of responding agencies reported fiscal year 1991 staffing below fiscal year 1990 levels. Overall, agencies projected a 2.1% decline in full-time equivalent staffing. Agencies avoided deeper cuts, in part, by withholding pay increases. Nearly half of all agencies provided no pay raises for their workers in fiscal year 1991, up from one-third the year before, and the average raise was just 2%. Despite this, turnover among human service workers declined in 1991 -- perhaps because the recession has limited other job opportunities -- and agency executives generally felt that the *quality* of staff was improving.

Caseloads Rise. Despite the resource limitations described here, 43% of responding agencies reported serving *larger* caseloads in fiscal year 1991. In fact, caseloads for active programs rose by 5 to 10% during the year. This is, in part, an artifact of the system-wide consolidation discussed below, with active programs expanding to accommodate the clients of now-discontinued ones. Over one-quarter of all agencies reported that they had closed or discontinued at least one program in the two years preceding the survey. Over 9% of all programs surveyed have been discontinued.

Waits Longer. The typical *reported* wait for services in fiscal year 1991 was 17 weeks, up 11% from the 1990 average of 15 weeks. The most significant increases in waiting periods were experienced by those looking for elder services (up from 4 weeks to 10 weeks), adult educational services (15 to 20 weeks), and job training (11 to 15 weeks). Also notable was a reported half-year wait for day care services. And these figures only begin to suggest the real levels of unmet need: In a 1990 survey conducted among Boston providers, nearly 40% of all programs reported that waiting lists did not reflect many clients that had been turned away.[3]

Client Needs Increase. Compounding these trends is the fact that agencies frequently reported that the service needs of clients have increased. Sixty-two percent of all program respondents reported that clients required "more intensive" care or treatment, 43% reported that more emergency services were needed, and 44% reported that clients required more long term services.

Social Needs Increase. In part, the rising needs of individual clients are a reflection of broader social and economic trends. Increases in social problems such as family and youth violence, and child abuse have been well documented, for example. In *Stressing the System*, we summarized some of these statistics: caseload increases in AFDC and General Relief, increases in AIDS victims, rising infant mortality and teen pregnancies, rapid increases in cases of child abuse and in the number of children in foster placements, increases in the numbers of battered women, persistently high drop-out rates in central city schools, and pockets of persistent poverty. Unfortunately, this litany could continue. In this crisis, these social trends are aggravated by economic troubles. One statistic serves here: between January 1990 and March 1991, the state's unemployment rate more than doubled, from 4.5% to 9.7%, and this upward trend is expected to continue.

Minority Communities. In *Stressing the System*, we expressed concern that agencies serving minority communities might be especially vulnerable to budget cuts. This concern was based on conventional wisdom that these agencies were, on average, smaller and less well capitalized than other agencies. This year's survey confirms these fears. It shows, for example, that agencies with caseloads comprised of half or more African American clients were smaller, more dependent on state funding, more likely to report a deficit in fiscal year 1990, and less likely to have financial reserves than non-minority agencies. Taken as a group, minority-serving agencies have also experienced deeper cuts in state contracts. The 1991 Budget Crisis Impact

Survey included questions, now being analyzed, which will help to define better the special roles which these agencies play in the community and in the system of care. This remains a critical on-going research issue.

Major Change for Community-Based Services Imminent

These trends, taken together, document the pressures which are mounting against private providers of human services from funding sources and from the community. These increasing stresses will lead to major changes in the system of care, and probably soon. As earlier stated, increasing consolidation will be among the most important of these changes and a trend toward services reimbursable through Medicaid is another.

Increasing Consolidation. Consolidation will be one of the most important of the changes occurring among private human service providers. Increasing mergers, failures and limited entry (new business formation) -- all typical economic indicators of industry "shake-outs" -- suggest that the early phases of system consolidation are now underway. Already, more than 25% of responding agencies have reported that a merger was being considered as "a possible course of action" in response to the crisis. More than a dozen agencies surveyed reported that they were either in the process of a merger or that they recently executed one. Although outright failures, another feature of shakeouts, are still comparatively rare among human service providers, amounting to as little as 3% of all agencies during the crisis (in number, about 40); entry into the provider community is also very limited. Only one responding agency began operations in 1990 and only 11 (2.5%) since 1988 (inclusive). It is also probable that the rate of failure would have been higher except for the direct intervention of state managers, who stabilized many troubled agencies on a case by case basis. Certainly, the financial data collected in the survey and presented here point to a higher failure rate than has been observed.

This trend toward increased consolidation will primarily be the "natural" result of prolonged resource scarcity and weak agency finances. That is, it will result from efforts to balance the state budget. Although agency-by-agency state contracting decisions will have affected this outcome, and some respondents report that they have been pressured to merge by state funding agencies, no overarching policy will have acted to produce this trend. This point is critical because, as the discussion below shows, increasing consolidation in the system of care may make some policy goals of the Weld administration more difficult to achieve. Also, because large-scale changes in the system of care are likely to become concretized, the administration and other policy makers may have to deal with them for the foreseeable future.

Given the likelihood of consolidation, it is important to ask how the character of the provider network, the menu of services available, and access to services will be affected by it. For example, since older and more traditional agencies are among the most financially stable providers, they are likely to survive the crisis and emerge to play an expanded role in the new "system of survivors". What are the implications

of this or other shifts brought on by consolidation? One of the aims of SPRG's current research is to describe how a consolidated system is likely to differ from the current network. That is, to discern the *directional* impacts of systemic consolidation.

Providers and Medicaid. A second major trend in privately provided human services is a shift toward services reimbursable through Medicaid. This trend is being furthered both by state policies that seek to shift costs to the federal government and the actions of private providers seeking financial stability. The move to Medicaid is similar to the trend toward consolidation discussed above in that it is driven mainly by bottom-line, and not programmatic, considerations.[4] It seems clear that the effects of this shift, while still poorly understood, may not always be desirable.

There are, in fact, two conflicting state Medicaid policies, and both are basically driven by budgetary concerns. The first addresses Medicaid as *budget buster*. Rampant Medicaid spending is generally considered to be the most pressing budget problem. It threatens to crowd out all other program spending. Fiscal year 1991 projected increases in Medicaid spending account for almost all of the spending rise for *all* human services. The aim of the budget-buster policy is to control the growth in Medicaid spending and its focus is narrowly placed on Medicaid line-item(s).

The second policy concerns Medicaid as *revenue*. Increased federal funding for human services is a frequently cited policy goal, and Medicaid is the key vehicle for achieving it.[5] Additional federal revenues are gained by redefining existing programs, or initiating new programs, to conform to models reimbursable through Medicaid. The new revenues gained in the process contribute to budgetary balance by reducing the *net state cost* of the program involved. Total *spending* is not reduced (and may even rise) as the program is shifted from a state-funded to a state- and federal-funded one, but *revenues* rise, leading to an overall budgetary benefit. The aim of this second policy is the same as the first, budgetary balance, but its focus is broader -- embracing the whole budget rather than only the medicaid issues. The mechanism it invokes for increasing revenues, however, is increased Medicaid spending. Therefore, the second policy directly contradicts the first. This conflict represents a significant challenge for state managers. Both of these policies are aimed at achieving a balanced budget, but -- because they conflict -- they need to be tracked separately to monitor the progress of either.[6]

The state is not alone in pushing for a shift toward Medicaid reimbursable programs. Private providers have acted to further the policy as well, and with good reason. Medicaid reimbursements promise a more stable (and adequate) funding source for services under its umbrella than agencies can achieve by *competing* for state contracts. Evidence from the survey suggests that this trend is already underway. One-quarter of the providers that receive Medicaid reported fiscal year 1991 increases in reimbursements of 50% or more, including a handful of agencies that initiated reimbursable services in fiscal year 1991.

But a shift among private providers toward Medicaid services is unlikely to have a significant effect on total Medicaid spending. Medicaid is simply not a large enough source of funding for community-based services. Only one agency in five had any reimbursable services in fiscal year 1991, and these reimbursements amounted to only 6.7% of the combined budgets of providers. These figures include community health providers. Among mental health, home health, and mental retardation programs, the rates of reimbursement are lower still. Working backward, these data imply that well under 10% of the overall state Medicaid budget is directed to private providers. The engine of Medicaid spending growth lies elsewhere.

The downside of budget-based Medicaid trends and policies is that they are likely to have significant programmatic implications which, so far, have not been considered. Most importantly, increasing reliance on Medicaid may lead to unwanted changes in agency and program mission. As noted above, increased federal reimbursements are sought by redefining existing programs, or initiating new programs, to conform to models reimbursable through Medicaid. These changes, sometimes described as the "medicalization" of human services, may lead to the loss of specific voluntary program services, such as counseling, which are not reimbursable, and a shift toward emergency and medical services, which are. Most likely lost in this transition are discretionary, non-clinical, early-intervention services. Ironically, these displaced services are generally less expensive in the short run and are believed to produce large prevention-related savings in the long run.

Conflict Between Budgetary and Reform Goals

The Weld administration brought into office an ambitious agenda to reform government. It also inherited a fiscal crisis which many believe to be the worst in the Commonwealth's history. The two distinct policy goals which arise from these two circumstances are often in conflict. Although budget decisions can act to further other policy ends; for Massachusetts, the immediacy and magnitude of the budget problem make this confluence difficult to achieve. The drive to achieve fiscal balance, pushed by the demands of the bottom line, takes precedence over any reform impulses. In the case of the Weld administration, it also appears to threaten reform by moving the system of care in directions which violate the policy guidelines that they have espoused.

For the Weld administration, the watch-words of reform are "entrepreneurial government". Based largely on work by David Osborne[7], the administration describes the entrepreneurial approach as market oriented, consumer driven, investment-oriented, decentralized, and focused.[8] These principles have become the basis for a wide reaching reform agenda, calling for the closing of state human service institutions, sweeping privatization, and reform of the budgetary and bureaucratic processes. When applied to private human service delivery, three tenets of entrepreneurial government are particularly important: providers should

compete, clients should choose their own provider, and decisions should be based on outcomes. Pursuit of entrepreneurial objectives, as we understand them, implies both the expansion of the private provider system (as part of a broader shift from governmental to private action) and substantial reform of purchase-of-service contracting.

Consolidation and Entrepreneurial Government. But increased consolidation conflicts with the entrepreneurial goals. Larger, consolidated agencies will tend to enjoy near monopolies within specific geographic service areas. This will limit the degree of competition among agencies as well as the choices for clients, who are unlikely to have the capacity to scour the state in search of better services. Since, as we argued above, the trend toward consolidation is a direct result of the fiscal crisis, the conflict between it and reform goals is a good example of the more general conflict between crisis and reform policies.

This is not an indictment of increased consolidation *per se*. We conclude, for now, only that consolidation conflicts with the *administration's* implicit policy goals. A more complete evaluation of the Governor's reform agenda, increasing consolidation, and other policies affecting privately provided human services is needed in order to make a recommendation regarding a *preferred* policy. The Social Policy Research Group plans to include a framework for discussing these choices in a future report.

Benefits of consolidation could include overall cost and overhead savings related to economies of scale and reduced fragmentation in the human services system (improving client access even as it reduces choice). On the other hand, the process of consolidation, as noted above, will transform the system of care. It is unlikely to be neutral with respect to agency missions and access to services. Many would argue that a provider network dominated by a few, large agencies will be more bureaucratic and less inventive than the current system. SPRG is particularly concerned that a consolidated service network may be insufficiently responsive to the minority populations of Massachusetts. For these reasons, we are pursuing more research on this question as part of this study.

Deinstitutionalization and Budget Balancing. The move to deinstituitionalize provides another example of how the drive to balance the budget conflicts with reform goals, and how, in this conflict, budgetary policy takes precedence. The first major reform proposed by the Governor was a massive plan to deinstitutionalize human services. The plan, which has not been fully described as of this writing, called for the closing of five or six public health and state-run mental health hospitals as well as a continued phasing-out of the state schools for the mentally retarded. The deinstitutionalization would be effected through increased reliance on private hospitals and the network of community-based providers.

But institutional reform appears to have been entangled in the exigencies of budget balancing. There is no doubt that an effective privatization plan will result in

budgetary savings and according to most experts, increased reliance on community-based care will also serve clients better. The problem is that, while the Governor's spending plan for fiscal year 1992 clearly shows evidence of deinstitutionalization, there does not appear to be a corresponding increase in the resources for community-based care. One way or another, deinstitutionalization will depend on the network of private providers. In this case, the overwhelming desire to minimize the spending bottom line may be clouding the equally important responsibility which the state has to provide quality care for these individuals. Budget cuts cannot substitute for reform.

Medicalization. Above, we noted that the drive to increase Medicaid funding of privately provided human services is likely to have substantial unintended effects on agency and program missions and on the menu of services offered. Further study is needed of these impacts, which may often be negative. As with consolidation, increased medicalization may also conflict with some of the precepts of entrepreneurial government. For example, the switch from state purchase-of-service contracts to Medicaid reimbursement may significantly alter the nature of competition among providers. Increased access to Medicaid reimbursements may therefore effectively reduce the amount of competition among providers. Also, *investment* and *prevention* are key words of the entrepreneurial approach as well. If the types of services lost are, as suggested, mainly voluntary and preventative in nature, then this too signals conflict between trends now underway -- and driven mainly by the need to balance the budget -- and other policy considerations. One of the common complaints of critics is that Medicaid policy only infrequently references larger health care issues, continually focusing instead only on budgetary impacts .[9]

Recommendations

The Commonwealth's options, given the magnitude of its budgetary shortfalls, are very limited. And this, in turn, limits the range of recommendations which outside observers, such as SPRG, can reasonably make. Criticism offered in such a constrained environment must be sympathetic to the obstacles faced by decision makers and to the seemingly impossible nature of their task. Still, with these caveats, we respectfully submit five general recommendations.

First, the Executive and Legislature must recognize the inherent conflicts between the short-term transitional goal of achieving a balanced budget and *any* long-term policy goals they may have. In order to preserve its options for the period when fiscal stability is restored, the administration should closely monitor vendor financial positions and divert resources, when necessary, to maintain the breadth and complexity of the system. In the future, policy-makers may choose to restructure the system in any number of ways, but some of these choices may be effectively obviated beforehand. To allow restructuring to occur in the absence of deliberate policy decisions is a mistake which may have long-term consequences.

To restate our earlier conclusion: restructuring driven by budget-balancing policies is no substitute for true reform.

Second, the administration should re-examine the adequacy of funding for those community-based services which will help effect successful deinstitutionalization. In this case, the desire to maximize budget savings has apparently clouded a potential reform measure -- the first undertaken by the Weld administration. Based on budget documents, little if any of the expected savings from deinstitutionalization has been channeled out into the system of community-based care. While an overall budget reduction should result from deinstitutionalization as a reform measure, the savings achieved must be determined in a manner consistent with the adequate provision of services.

Third, the earlier movement to reform the Commonwealth's purchase-of-service system should be revived as an integral part of the larger entrepreneurial government reforms. Given that these reforms promise to place a larger emphasis on private service delivery, it makes sense to fix this system before putting more money and responsibility into it. Fortunately, a comprehensive plan for reform already exists. Moreover, as developed by the now-defunct Office of Purchased Services, this plan is generally consistent with the aims of the entrepreneurial model. Few of these changes have been acted upon, however, and most are now dormant for want of funds or attention.

Fourth, the larger effort to reform purchase-of-service contracting should include plans to improve the degree of integration and communications among providers and programs in order to improve access for clients. In *Stressing the System*, we found only loose client referral connections among agencies. More than 70% of all clients left provider agencies without any referral at all and only 17% were referred to another private agency. These findings conflict with the widespread conviction that many clients suffer from multiple problems, each potentially requiring distinct services. Other research has shown that the awareness would-be clients have of helping services is limited, especially among the poor.[10]

Finally, the Commonwealth should act to develop the basic knowledge base upon which all reforms should be built. This study represents one such effort but more is needed to augment the provider agency perspective employed here. Ultimately, reform of the human services system depends upon re-discovering the individuals it serves, and requires a much deeper understanding of individual clients than is presently available. In response to this need, SPRG plans to survey human service clients directly. The survey will provide the first comprehensive profile of human service clients, as well as a snapshot of how they actually access and use the system of care. It's goals will be to describe the client population, identify common concurrent service needs of clients, identify services that are central to the operation of the whole system, and understand how human service clients find their way around the system of care.

NOTES

[1]Weld/Cellucci Plan for Fiscal Recovery: 1992" (House No. 1), Vol I, p. II-1

[2]*Stressing the System*, p. 1

[3]Source: The Social Policy Research Group sample survey of Boston providers conducted in May, 1990. Unpublished.

[4]The two trends may also be intersecting. We have received several anecdotal reports that mergers with hospitals are among those most frequently discussed by providers.

[5] As a policy goal, increasing federal participation is not new -- it was also frequently cited by the Dukakis administration -- but it appears to have gained momentum under Weld. For one example, Massachusetts recently secured a large, retroactive, reimbursemnent from the federal government for certain free care provided by health care providers. Another example: The state recently received a dramatic increase (from 1200 to 2600 clients) in the federal waiver which allows community-based mental retardation services to be reimbursed under Medicaid.

[6]From anecdotal reports, it seems that state managers and policy makers cannot always keep these two policies clear. The current debate over optional Medicaid services provides a good case in point. In some cases, these benefits provide a 50% federally-funded substitute for 100% state-funded services. Take, for instance, Personal Care Attendants (PCAs) who provide day and work preparation and other services for the adult mentally retarded and other handicapped. If the optional PCA service is cut from Medicaid, more state dollars will be required to provide the same service -- if it is to be available. Some advocates are pushing for more optional services, not fewer, and point to overall budget savings: An example would be to expand federally-funded home care as a substitute for state-funded programs.

[7]See David Osborne, *Laboratories of Democracy*, Harvard Business School Press, Boston, 1988 and "Ten Ways to Turn D.C. Around", *The Washington Post Magazine*, Dec. 9, 1990.

[8]Weld/Cellucci Plan for Fiscal Recovery: 1992" (House No. 1), Volume I, part 1.

[9]One advocate described the Medicaid cuts proposed to date as a "nickle and dime" approach. "The [implicit] power structure identified when the *budget busters* label was first applied is being overlooked -- they are not being discussed."

[10]*In the Midst of Plenty*, The Boston Foundation, December 1989, p. 53.

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